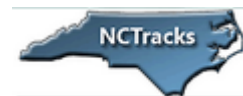




NC DMA Carolina ACCESS Referral Form



Recipient Information

DMA-0009

Recipient ID #: _____
Last Name: _____ First Name: _____
Date of Birth: _____ Gender: _____

Referring Provider Information

Referring Provider's NPI #: _____
Referring Provider's Name of Practice: _____
Site Address: _____
City: _____ State: _____ 9 Digit Zip Code: _____

Referred to Provider Information

8. Referred to Provider's NPI #: _____
9. Referred to Provider Name of Practice: _____
Site Address: _____
City: _____ State: _____ 9 Digit Zip Code: _____

Referral Information

10. Referral Type: ☐ Evaluate ☐ Treat ☐ Evaluate and Treat
11. Referral Start Date: _____
12. Referral End Date: _____
13. Number of visits: _____ ☐ Unlimited visits (unlimited visits with no end date)

A Referral does not guarantee payment. Payment of claims is subject to compliance with DHHS guidelines and restrictions

Complete this form to request a Carolina ACCESS referral be processed by CSC. Instructions for completing this form can be found at <http://www.NCTracks.com/Referralformhelp>

Requestor's Name _____ Phone Number: _____ Ext _____

Referring Provider's Signature: _____ Date: _____

Fax this form to CSC at: (855) 710-1964